Course Introduction

As this course points out, rural mental health services are far behind its urban counterparts in encouraging and supporting consumer participation. This is due to a variety of factors, but with less community and political fragmentation that has typically characterized rural mental health policy, services could become more attainable for those in such communities. The best practices for rural mental health service delivery need to be identified, documented, and disseminated. For example, rural mental health professionals will need to be effective in treating co-occurring disorders that include both a mental disorder and substance-related problem. Similarly, just as other counselors need to possess multicultural competence, rural mental health practitioners need to attain rural community competence.

Learning Objectives

Upon completion of this course, you will

- the basic components of rural life and rural mental health
- the difference between urban assumptions and rural realities
- about rural mental health and the threat of managed care
- information about the strategic focus of rural mental health

Course Content

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Understanding Rural Mental Health in the United States

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"...most Americans have only the remotest connections with the day-to-day realities of rural America and most frequently idealize its value while passing through on summer vacation or flying over in a transcontinental jet"

-Stock (1996)

Approaching the century mark, many of the themes of rural mental health remain constant: mounting needs and limited resources; unique geographical and cultural challenges to service delivery; severe shortages of professional staff; service providers struggling to operate under urban models and assumptions imposed by funding sources or regulators; consistent misunderstanding of rural realities by State and national policymakers; the tendency to not take rural into account in public policy or the tendency to want a single policy solution to rural mental health issues; rural mental health advocates still struggling to be heard and more often than not left out of important policy discussions; the enduring strengths of rural mental health being glossed over or forgotten (Beeson 1990, 1994; Human and Wasem 1991; Kimmel 1992; Larson et al. 1993; National Mental Health Association 1988; Merwin et al. 1995; Pion et al. 1997; Wagenfeld et al. 1993).

There is still debate about what is rural; whether it truly costs more to deliver services in rural settings; whether rural populations are at more, less, or equal risk for mental disorders; which models are best for meeting the mental health needs of rural residents; and whether new forms of payment for services (e.g., managed care) will harm or help (Johnson-Webb et al. 1997; Ciarlo et al. 1998; Wagenfeld et al. 1993).

On a positive note, rural mental health is receiving increased national attention (Rauch 1997), and there are more efforts to understand the unique needs of particular rural populations such as those living in frontier areas (Ciarlo 1998). Telemental health is making headway, providing important connections to rural and remote areas. The Internet is becoming a vehicle for greater connectivity among consumers, providers, and families. Some managed care ventures are using innovative approaches to increase access and availability.

The recovery movement is providing a new paradigm for consumers, families, and professionals to work together toward a more hopeful and empowering goal (Cooper and Dennedy-Frank 1998). There continues to be a number of model rural mental health programs that offer innovative solutions to the difficult problems of rural practice (Mohatt and Kirwan 1995). There is renewed interest in improving the integration of mental health and primary care services in rural settings (Bird et al. 1995, 1998; Size 1998).

This chapter does not simply reexamine the many long-term problems that beset rural mental health. Instead, we focus on three defining aspects of today and two major areas of influence that are shaping its future. The first
Rural Mental Health Today

Rural life and rural mental health are intimately intertwined. It is impossible to consider rural mental health without understanding what is happening in rural America. Rural mental health problems and practice cannot be separated from the context in which they occur. Though inseparable from rural trends and realities, rural mental health cannot escape the dominance of urban models and mind sets that pervade mental health policy. The urban world colors and constrains every aspect of rural mental health service delivery. Despite the challenges of rural practice and the constraints of urban models, there remains a set of several enduring strengths of rural mental health.

Rural Life and Rural Mental Health

Danbom (1995) noted that rural Americans have declined “from majority, to minority, to curiosity.” Rural residents are not only declining in number, they are also rapidly losing political power and influence. As Dyer (1997) recently reported, “Rural people feel powerless and disenfranchised because they are powerless and disenfranchised.” Increasingly, people in positions of power and influence have no experience with or realistic knowledge about rural realities, resulting in either massive indifference or gross naiveté.

It used to be that a majority of mental health policymakers had some rural connection. Perhaps they were one generation removed from the farm or possibly they had spent a summer on an uncle’s farm or had friends who lived in the country. Today, that is typically not the case. Today’s mental health policymaker’s ideas about rural areas come mostly from the urban-based and -biased media. Rural people are often portrayed as either quaint, unsophisticated “good souls” or dangerous, bigoted, backward “rednecks.”

This political disenfranchisement of rural Americans is reflected in the lack of policy attention rural mental health receives at the State mental health authority level. Ahr and Holcomb (1985) found that rural mental health services were close to the bottom in a ranking of priorities of State mental health program directors. Kimmel (1992), in surveying the same group, found that there were few State mental health staff with full-time responsibility for rural issues and that State mental health agencies were rarely asked to address rural issues in a direct and sustained way. What this finding implies is that while virtually every other “special” constituency has advocates in policy and decision-making conditions, rural residents, an estimated 56 million individuals, are at best, underrepresented.

Rural economies are struggling, and many rural areas face dwindling populations and eroding economic bases. In those rural areas where there is growth, it often has an adverse effect on the local population and infrastructure. Growth due to mining tends to produce boom and bust cycles that wreak havoc on local economies and services (Harman 1998). Growth due to industries, such as meat packing or prisons, often overwhelms local housing stock, schools, and health services and changes the social and ethnic makeup of
communities. Growth that results from recreational development often drives up land values and taxes, resulting in the displacement of local populations. In many cases, the result of rural economic development is a dramatic increase in mental health and substance abuse problems and a corresponding decrease in the political and economic influence of indigenous rural populations (Weisz 1979).

While people often talk and write about rural areas and populations as a homogenous group, it is important to remember that there are likely more differences within the category of rural than there is between the categories of urban and rural (Cordes 1990). Rural areas in the United States are remarkably diverse in both geographical character and the culture of indigenous populations. Delivering mental health and substance abuse services in the Deep South is considerably different from responding to those same problems on the Great Plains. Differences in ethnic heritage, population density, and economic base make “one size fits all” solutions to rural mental health problems impossible. The types of disorders and the manner in which they are experienced, as well as their relative frequency, are likely to be different if the area’s primary economic base is farming, ranching, mining, lumber, tourism, or fishing.

The treatment approaches that are effective in working with black subcultures in the Deep South are not likely to work with Native American populations in the southwest. The service delivery issues facing providers in the relatively densely populated areas of the east are quite different from those facing the service providers in the remote and isolated frontier areas of the west (Wagenfeld and Geller 1998). Finally, of paramount importance, consumer experience, needs, and the acceptability of different types of mental health providers often vary dramatically from one rural setting to another.

Rural America has traditionally been viewed as a rather stable environment, somehow isolated from the many dramatic changes that occur in mainstream urban and suburban society. However, the farm crisis of the 1980s and the continuing economic decline of rural America in the 1990s have produced dramatic social and economic challenges that have a direct impact on the mental health of rural Americans (Hoyt et al. 1995; Ortega et al. 1994). Many rural economies no longer depend on agriculture as the primary source of employment. There are an increasing number of rural jobs in manufacturing and services. Rural economic health is now affected by the same national trends, such as increased foreign competition, that affect urban areas (Meeks and Lawrence 1988).

Rural mental health has a long history of being a public enterprise. It has been, and continues to be, dependent upon public funding and support. This, however, is changing (Manderscheid 1998). First and foremost, policymakers at all levels are increasingly unwilling to subsidize either people or services. Second, there is increasing privatization of public mental health and social services. For example, many State governments are contracting with private companies to manage their Medicaid, public mental health, and child welfare programs. Third, the development of health care networks is forcing rural mental health and substance abuse providers to “join up” or be left out in the cold. Many of the decisions that will affect rural mental health care delivery in the future will likely be made outside of government and outside of rural settings. Because of the relative over dependency on public moneys, rural residents will experience considerably greater impact from these trends. Perhaps because of the greater saliency of stigma or isolation among rural people, they appear to have far fewer opportunities for consumer and family involvement and support. The relative dearth of consumer focus and leadership is significantly lower than even what one might expect because of the relatively low population density. Some have argued that this is simply a reflection of the general leadership drain in rural areas where out migration in search of jobs and other opportunities (perhaps, in these cases, treatment and rehabilitation opportunities) has stripped rural America of leadership in all areas. Another, and more likely, reality is that rural
mental health programs, in part due to their resource poor nature, have not devoted sufficient resources to such specialized functions as consumer empowerment, involvement, and support. Regardless of the causes, the lack of consumer and family focus and leadership in rural mental health is a serious void.

**Urban Models and Mind Sets**

Urban models and minds sets are the yoke of rural mental health. While most mental health providers complain of “cookie-cutter” approaches imposed by centralized bureaucracies, rural mental health is at a particular disadvantage (Beeson 1983). Even the hallowed community mental health center model of the 1970s was characterized as an “urban model,” antithetical to the social structure of rural communities (Berry and Davis 1978). Through policy, regulation, financing mechanisms, and standards, the urban world is imposed upon rural mental health practitioners and programs (Sawyer 1998). These constraints are a major barrier to effective service delivery and program operation. The “mental models” (Senge 1990) of urban-based policymakers, funders, and regulators fail to take into account the realities of rural mental health practice. These taken for granted assumptions about the world and how it works find their way into funding requirements, requests for proposals, regulations, licensing or credentialing standards, policy directives, practice guidelines, training materials and programs, ethical standards, funding decisions, and so forth. This results in rural mental health providers having to operate under bureaucratic conditions that often are at odds with the world within which they must deliver services. The classic, but by no means only, example of this is the situation that comes up regularly where someone wants to ban “dual relationships” (where the mental health professional has an additional relationship with a client other than the one of therapist-client). However desirable such a standard is, it is clearly unworkable in rural communities where everybody knows everybody, and people would be denied needed services.

The increasing call for best practices, service protocols, and practice guidelines are new areas of risk where urban models are likely to be imposed on rural mental health practice, with serious consequences. For example, a study on the implications of implementing practice guidelines for the care of people with noninsulin dependent diabetes projected dramatically increased rural health workforce resource demands. Focusing on the rural Medicare population, the study by the Minnesota Rural Health Research Center (1997) concluded,

> When all the additional recommended laboratory tests, procedures and visits are taken into account, we estimate that treating diabetes alone would require the full-time attention of twenty additional primary care physicians and fourteen additional ophthalmologists in the rural regions of Minnesota.

Table 1 summarizes predominate urban assumptions about mental health practice and the corresponding rural realities. These differences have important implications for today’s world of managed care. Urban based models assume a world dominated by duplication of services, adequate (if used correctly) resources, overabundance of specialized mental health professionals and providers, over utilization of services, the cost effectiveness of specialization, and an obligation to clients that is narrowly focused on “treating a mental disorder.” In contrast, the realities of rural mental health practice include a lack of availability of services, scarcity of resources, severe shortages of specialized mental health practitioners and providers, the underutilization of services, the impracticality of specialization, and a recognition that to be effective, clients must be supported beyond the narrow range of medically necessary specialized mental health services. A set of managed care strategies based upon the assumptions of the urban model can have devastating effects in rural areas as mechanisms are put in place that seek to reduce utilization, narrow the scope of services provided, require specialization, and so forth.
As more and more decision making and control is centralized in urban (or out of State) corporate or government offices, there is an increased risk not only to the accessibility and quality of rural mental health care but also the very existence of the fragile rural mental health care infrastructure (New York Rural Health Research Center 1997).

In addition to the urban assumptions that find their way into policy, there are urban mindsets that have to do with rural mental health. There is a general belief that urban settings have much greater need for mental health services than rural areas and deserve more funding. Rural mental health problems and associated social problems (e.g., poverty, homelessness, domestic violence, drug abuse) tend to be less visible (they are not things you encounter on the street every day or see on the local news every night) and can lead to the erroneous conclusion that rural areas have a lesser need for mental health services.

In some cases, such as substance abuse, the overall problem may be equal in rural and urban areas, but urban areas appear to have more of a problem because the problem manifests itself in a greater variety of forms (e.g., greater abuse of a variety of drugs in urban areas whereas substance abuse in rural areas tends to be dominated by alcohol abuse) (Blazer et al. 1985).

There is the belief, based upon economic rationality, that it is simply not cost-effective to develop mental health services for rural populations and that the money it costs would be better spent serving a larger number of people in an urban setting. There is also the belief that rural people choose to live in rural settings and by this choice are accepting the reality that they will have less access to services (and, therefore, services do not need to be developed). There is another urban-biased belief that there are too few people in rural settings to do good science or a good test of a model. As a consequence, rural mental health researchers and rural providers wanting to participate in demonstration projects are at a distinct disadvantage.

These problems are not new. Rural Americans have always suffered from the tendency for policymakers to base their actions on a rather narrow range of personal experience that is urban and East Coast-based (Stock 1996). In recent years, however, this trend has accelerated as a new generation, which has almost no rural connections or experience, assumes positions of authority. Mostly, these urban models are imposed out of ignorance or expediency. There is, however, an attitude that rural areas and populations do not warrant any special consideration. In a curious kind of reasoning, it is assumed that to take rural into account in policy would somehow be unfair to others, while forcing rural mental health practitioners to operate under conditions designed for urban populations and areas is considered equitable.

The Enduring Strengths of Rural Mental Health

While rural mental health practice suffers from a lack of resources, the constraints of urban models and mindsets, and unique problems of service delivery, it has a number of enduring strengths.

First and foremost is a commitment to rural. There is a reason one talks about rural mental health rather than mental health in rural America. It is because a focus on and a commitment to rural people and their problems has always been the priority and unifying force in rural mental health. This belief that “rural” comes first has allowed the field to be relatively free of the turf battles and guild issues that have so fragmented the general field of mental health. Too often in the broader mental health arena, consumer needs have taken second place to the tiffs between academic disciplines and the various professions.
Second, rural mental health practitioners possess a special set of competencies. While it is not always fully articulated or appreciated, the design and delivery of rural mental health and substance abuse services requires a unique set of knowledge, skills, and abilities (Beeson 1991a,b, 1992, 1998).

Rural mental health practitioners have learned how to deliver mental health services to diverse and isolated populations, strategically leverage scarce resources to support their clients, and incorporate community resources into effective treatment plans. Rural mental health professionals are expert at using the full range of community resources and assets as instruments of recovery for persons with mental and substance abuse disorders.

Third, the rural community itself is an important strength of rural mental health. Rural communities, by and large, know their members and support each other. Community members and institutions (e.g., churches) often step in to support consumers and their families in times of crisis and illness. The lack of anonymity works in positive ways to ensure that consumers do not become isolated and that clients having problems are quickly brought to the attention of rural mental health practitioners.

Rural communities are often very supportive, providing encouragement and reinforcement for client improvement and consolation and support in times of difficulty. It should be noted that there are, however infrequent, some occasions when a rural community does, in fact, close ranks against someone who has a mental disorder.

Fourth, rural communities have a set of social institutions (family, church, government, voluntary associations, etc.) that are, for the most part, more accessible than urban social institutions to persons with mental disorder. They offer roles and opportunities, a place to belong, that is often absent in more urban social worlds. Most rural communities have, in fact, a socially recognizable role for each of their citizens, including persons with mental disorder.

There is an inclusiveness in rural communities and a tolerance for individual differences that provides for a strong integration between persons with mental disorder and the social fabric of the community. There is a connectedness available to persons with mental disorder living in rural communities that stands in sharp contrast to the isolation and abandonment that many of their counterparts experience in urban settings.

Fifth, rural mental health professionals are often in a position to provide more individualized focus on their clients and to customize their treatment to the individual’s unique circumstances to a greater extent than their urban counterparts. This is due in part to the greater knowledge rural practitioners are likely to have about all aspects of their clients’ lives and personal circumstances. It is also a benefit born out of the scarcity of service options. Rural mental health professionals are less likely than their urban counterparts to have a variety of standard programs to fit clients into and, therefore, are less constrained by the bureaucracy of programs.

Sixth, rural communities are more often than not very appreciative of the work of rural mental health professionals and are more likely than their urban counterparts to recognize the expertise and value of the rural mental health professional. The rural mental health professional is often included in community decision-making and has more leverage in influencing community decisions that may have an impact (positive or negative) on the mental health of the community. In other words, rural mental health practitioners have a greater probability than their urban counterparts of making improvements at the community level and, thus, are more effective in the prevention of mental health problems.
Seventh, rural settings are often safer environments for persons with mental disorder. Persons with certain types of serious mental illness find in rural settings an escape from the detrimental aspects of over stimulation, frenetic activity, and fast pace of life that dominates metropolitan living. In addition, rural settings generally have less crime, and persons with mental illness are at less risk for victimization and exploitation.

While rural environments are by no means totally pastoral and stress free, they often place significantly reduced burdens of everyday coping on persons with serious mental disorder and, as a consequence, provide a safer and more conducive atmosphere for recovery. The one major qualification to this assertion is that, for persons with certain mental disorders, the isolation experienced in some rural settings can be detrimental.

Eighth, rural communities, because of their smaller size, and fewer power brokers, have a unique opportunity to develop and maintain collaborative relationships with those who control funds, not only in mental health, but across health and human services, and the entire gamut of funding streams within the community. This has the potential to result in better coordination and integration of mental health services with other services and less duplication of effort.Scarce resources can be more effectively leveraged to support mental health consumers and families.

**Rural Mental Health Tomorrow**

Two new areas of technology (managed care and information technology) inspire both hope and fear in the minds of rural mental health consumers and practitioners. The trends and developments in these areas offer both promise and threat. Of all the factors that are currently influencing rural mental health, these two areas are likely to be the source of much of what shapes the rural mental health care of tomorrow.

**The Opportunities and Threats of Managed Care**

The arguments regarding the risks of managed care to rural mental health are well known (Beeson 1993, 1994; Manderscheid 1998; Miller 1996; New York Rural Health Research Center 1997). In rural America, very little has been done to develop behavioral health managed care models that will provide residents with cost-effective services that are both available and accessible. Behavioral health managed care contracts are typically based upon statewide or regional geography, with no consideration given to the differences in how services should be delivered between urban and rural constituencies. As a result, where rural behavioral health managed care systems do operate, they are usually scaled-down urban models, or worse, ones which require rural constituents to travel to urban areas to receive some of their services. As the distance traveled to access services increases, it is increasingly difficult for the rural consumer to fully participate in, and comply with, treatment services.

In the past 5 years, there has been a significant trend toward consolidation of the private sector-managed behavioral health care companies. According to one behavioral health analyst, recent mergers and acquisitions have left 84.4 percent of the market share in the top 12 managed behavioral health care companies, 60 percent in the top 3 companies (Open Minds 1998). For the largest managed care companies, mergers and acquisitions help create a situation where cost savings, through the economies of scale created, can be offered the payer source. While on the surface this is a desirable effect, it does make it extremely difficult for smaller national, regional, and particularly rural-based behavioral health entities to compete, on price, management information systems, service menus, and other areas. The economics of consolidation require these large managed care entities to manage their services very tightly in order to pay the various costs associated with conducting mergers and acquisitions. This “managing tightly” too often means reducing or eliminating the flexibility and service supports (e.g., transportation) needed in rural mental health.
It seems inevitable that the private, nonprofit providers that historically constituted the majority of rural behavioral health service providers will have to contract with one or more large managed care corporations, which will insist upon compliance with standards and practices which may be difficult to achieve in the rural environment. In addition, rural service providers generally do not have the cash reserves and organizational infrastructure to survive in an environment of competition with larger, well-financed private, for-profit organizations. Strategic collaborations between the public and private sectors will be necessary if rural behavioral health needs are to be met.

On the other hand, consolidation within the behavioral health managed care industry does provide opportunities for rural service providers. Rural providers have local knowledge and a history of providing services that will make them attractive partners to managed care organizations (MCOs). Within this history is usually a demonstrated ability to be flexible in both the design of services and their implementation. Large organizations tend to lack the ability to respond in a flexible manner to varying public needs, and therefore look to securing contracts with provider organizations who can. Further, linking with a larger behavioral health network can increase the rural mental health provider’s access to highly specialized mental health services, consultation, and backup. There are also increasing opportunities for small rural mental health providers and networks to contract with administrative service organizations to provide them with the necessary infrastructure (e.g., information systems, utilization review capacity, billing) to be competitive.

Another crucial trend is the increased use of the principles of managed care in public sector behavioral health programs and particularly in the area of serving more disabled populations, such as adults with serious and persistent mental illness and children with serious emotional disturbance (Mechanic 1998). Over 40 States now operate some type of managed care model for mental health and/or substance abuse services (SAMHSA 1998). Rural behavioral health service providers can forge strategic alliances with other service providers in their communities and form entities that can provide effective services to these at-risk populations. Knowledge of the principles of managed care and a willingness to work collaboratively with other service providers will result in a greater marketability to contracting entities, be they private sector MCOs or public sector entities seeking to operate their own managed care programs.

As traditional mental health and social service organizations become more sophisticated in the use of managed care technology, they are likely to adopt a more entrepreneurial stance toward expansion. Rural areas will be seen as more attractive for urban-based health and human services organizations. Small rural providers are likely to face more competition as urban-based entities bid for contracts to provide mental health and other services in rural areas. These organizations will likely seek to achieve economies of scale in rural areas by becoming multiservice organizations that combine mental health, developmental disabilities, child welfare, juvenile justice, and other publicly supported programs. The real question facing rural mental health is not going to be if they integrate with other systems but whether they go the route of integration with health care systems or human service systems or both.

Historically, rural mental health programs have enjoyed a special relationship with their funding sources. Under these new, statewide contracts with an emphasis on integration and capitation, the question arises, will traditional rural providers lose ground? There will be increasing pressure for State and local government to allow for increased competition for mental health contracts and grants.

Many States, including Massachusetts, Iowa, Tennessee, New York, and Oregon, are in various stages of altering their Medicaid mental health systems (Calahan et al. 1995; Christianson and Gray 1994; Christianson
Each of these States has expanded eligibility for Medicaid, replacing fee for service with capitation and introducing managed care techniques such as utilization review. Implementation of the Oregon Plan produced substantial objections, since it radically altered traditional provider linkages and networks (Cutler et al. 1998). Yet another trend with potential impact on rural areas involves the integration of health and behavioral health services. Again, collaboration between rural health and mental health service providers will be a key factor in establishing viable organizations through which MCOs can contract for services (Size 1998). There is substantial evidence that primary care providers and the people they serve could benefit from a closer integration and collaboration with mental health providers (Borus et al. 1985; Mental Health Reports 1990; Narrow et al. 1993; Pallak et al. 1993). The integration of health and mental health services in rural areas through enhanced communication between the respective professional service providers, colocation of program facilities, and a systems approach to treatment planning and service provision will provide unique opportunities for rural communities to negotiate with MCOs for the provision of behavioral health services.

Finally, the increased participation of consumers and family members in the development of behavioral health services is a trend long overdue (Manderscheid 1998). In rural America, much work remains to be done in encouraging all stakeholders to do much more than provide input into the development of behavioral health services; they must drive all aspects of program development, implementation, and evaluation.

Managed care organizations are increasingly including consumers and family members in program development activities that are requiring consumer participation in their network provider organization. As with the other trends identified, to the extent that rural communities can identify and utilize the expertise of rural consumers and family members in all aspects of the service development and delivery systems, they will be in a stronger bargaining position with MCOs.

**The Promises and Pitfalls of Technology**

Telecommunications technology offers one of the brightest hopes for improving access to and the quality of mental health services delivered to consumers and families in rural areas (Britain 1996; La Mendola 1997; Smith and Allison, forthcoming). The increased deployment of advanced telecommunications services and decreased equipment and carrier costs have made it possible for mental health providers to overcome the geographical and distance barriers present in rural settings.

With the advent of video conferencing and computer-based technologies, specialists who typically do not practice in rural areas can now become virtual members of the local service delivery team. The economic and time-loss burdens of travel are alleviated for both the consumer and the specialist. Service planning is more inclusive as teams can come together virtually; consumers can often remain in their communities and with their families during acute periods; and when hospitalization is required, those important ties are maintained.

Local access to the Internet is becoming more available to providers, consumers, and their families in rural areas. With it comes access to information regarding medication and treatment, research, and opportunities to interact with specialists from all over the world. Providers can network with each other, reducing the negative impact of isolation that practice in rural areas often brings and increasing the likelihood that the practitioner will remain in the rural setting. Consumers and families can find supportive environments in which they can grow and recover. The rise of the “virtual university” and other distance learning opportunities means enhanced staff development and continuing education opportunities for rural mental health practitioners.
The development of electronic patient records that can be transmitted instantly to wherever they are needed or carried by the patient in the form of a “smart card,” much like a credit card, allows providers to give more immediate and often better care to the patient. Information can be quickly shared with other providers on a need-to-know basis.

With all these advances, there are some concerns. Despite the increased deployment of telecommunications services to rural areas, is a two-tiered system being created? Will those who have access to the technology receive better care than those who do not? Will the technology be used appropriately to improve access to and quality of care? Or will it be used by payers only to cut costs and expedite care? Will patient records really be secure and only go to those who need to know?

A central question in this area is that of cost differences between rural and urban settings in accessing carrier services and the availability of those services. In many rural areas, high-speed transmission lines are not available or, if available, are considerably more costly than in urban settings (e.g., a T1 line that costs $300 per month to lease in an urban area can cost up to $2000 per month in a rural area).

Many of these pitfalls will be avoided if rural providers, consumers, and their families are involved in the development of guidelines for the appropriate use of the technology to deliver service. It is doubtful that rural populations can rely on the marketplace for affordable access to telecommunications any more than they were able to rely on the marketplace for access to electricity. Rural people will need to continue to work together and advocate for their telecommunications needs.

Conclusions
Four areas of focus should guide rural mental health in the future. The first is rethinking the strategy by which rural mental health issues and problems are addressed. The second is a focus on behavioral health managed care contracts to ensure that they are rural friendly. The third is consumer leadership development and involvement. The fourth is ensuring that new technology will benefit, not disenfranchise, rural mental health. We take each of these in turn.

Rethinking the Strategy
Many in the rural mental health community continue to feel that if policymakers were to truly understand, they would appropriate needed funds to meet the mental health needs of rural residents and eliminate the barriers that constrain rural mental health practice. Too often, rural consumers and providers see themselves as victims and grumble to State and Federal officials about being left out or unfairly treated. They look to others for the answers, to be rescued from their plight, believing that with the right resources and appropriate public policy, it would be possible to meet all the mental health and substance abuse needs of rural residents. To some extent, this approach has worked. There are (or have been) Federal training, research, and technical assistance programs that target rural mental health, and there is greater recognition and increased appreciation of the problems of meeting the mental health needs of rural residents. But for the most part, this strategy of “whining and begging” has resulted in temporary infusions and spotty fixes to a set of enduring problems.

Rural mental health systems need to shift their focus away from being the victim and from waiting for government (State or Federal) to recognize their plight and give them assistance. We propose a two-pronged strategy involving public-private partnerships and legal and legislative action.
The first step is to move away from trying to address rural mental health problems through government handouts. The rural mental health community needs to identify those private sector entities (e.g., managed care corporations) that have a vested interest in successfully meeting the mental health needs of rural populations and forge partnerships where mutual interests coincide. Strategic public-private partnerships can be developed to address rural mental health issues, and this strategy is recommended by the National Association for Rural Mental Health (NARMH) in its Rural Mental Health: 2000 & Beyond (Sawyer and Beeson 1998).

NARMH has called on the rural mental health community to take charge of solving its own problems. NARMH has called for the creation of public/private partnerships along with coalitions of consumers, families, and mental health professionals to address the problems facing rural mental health. NARMH has set forth a set of strategic areas of focus (Five Cs for the Next Century) to guide the effort they believe will enhance rural mental health well into the next century (table 2). Rather than a concrete set of goals and objectives, NARMH is calling for a process, a process of development that is focused on these five Cs. A central part of this process is involving a new set of partners to address the enduring problems of rural mental health.

The second step is to recognize that rural people have become a disenfranchised minority and that, like other disenfranchised minorities, they may need to seek protection and relief from the courts and through legislation. The urban bias of mental health policy is likely to continue to grow, and it will become increasingly difficult for the voice of rural mental health to be heard. It is time that the rural mental health community began preparing a legal strategy to protect itself from unrealistic requirements and standards and inequitable distribution of resources. This legal strategy should include both the development and promotion of legislation that provides protections for rural mental health consumers and providers and the seeking of relief from the courts when actions are taken that are detrimental to rural mental health consumers and providers.

**Focusing on MCO Contract Development and Monitoring**

One of the primary opportunities for influencing the impact of behavioral health managed care on rural mental health is through the contracting process (Keller, forthcoming). There are two areas of contracting one needs to consider: the contract between the payer (e.g., a State) and the managed care organization and the contract between the MCO and the provider. In both cases, there are three phases to consider: the Request for Proposal (RFP)/Qualifications (RFQ) process, the contract negotiation process, and the contract monitoring/compliance process.

In the RFP process, it is important that States communicate enough information about the realities of their rural environments and the State’s expectations regarding access and the protection of fragile rural mental health infrastructure that potential bidders can make sound decisions about whether their organization has the capacity, expertise, and interest to pursue such a contract. A critical aspect of the State RFP is its commitment to quality as one of the principle bases for awarding the contract. As Manderscheid (1998) has argued, failure to focus on quality will reduce the competition to cost, and more resources will be diverted from rural mental health care.

In the RFQ process, it is important for rural mental health providers to obtain as much information as possible from the MCO regarding outcome expectations, utilization review practices, credentialing standards, data and reporting requirements, and so forth in order to make sound decisions about whether they have the capacity and interest to be a provider organization for that MCO. Rural mental health providers should keep in mind that, in many cases, they are the only game in town or the only comprehensive game in town, and it would take a considerable investment for an MCO to install a new provider in their area. In other words, rural mental health providers may have more leverage in the contract negotiation process than they think.
Contract negotiations should result in very clear contract language regarding how the MCO will assure access and quality in the rural parts of the State and what data (outcome and performance measures) will be used to determine compliance (Keller, forthcoming). A crucial part of this is ensuring that the data the MCO is required to submit are structured in such a way that an analysis of the impact on rural areas and populations is possible. Rural provider organizations should make sure their rights and obligations are clearly spelled out in contracts.

Rural consumers and families should be meaningful participants in the MCO contract development process. As recipients of the services, they are more knowledgeable about services, interventions, and system problems than many of the State officials who are typically charged with designing the features of a contract. However, individuals with serious mental illness and their families have not consistently had an opportunity to review and suggest improvements to service delivery during the contracting phase. Their involvement in this process is a logical extension of the consumer-rights movement which began in this country during the 1960s.

Concerning the contract development process, consumers and families should have the opportunity to advocate for standards and performance criteria that are specific to rural and frontier areas. In particular, when contracts are developed, process and outcome indicators should be included that make sense in low population density areas. Consumers and their families should have an adequate opportunity to advocate for contract language that ensures adequate service delivery in less populated areas, especially when statewide contracts for behavioral healthcare services are being considered.

Monitoring for compliance should rely both on consumer/provider input and data on access and quality. The State should be prepared to intervene rapidly should the MCO fail to live up to the contract or violate its contracts with provider organizations. The State as well as local mental health providers should have a “plan B” should the need arise to cancel the MCO contract.

Enhancing Consumer Focus, Leadership, and Meaningful Participation

Regardless of the causes, the lack of consumer and family focus and leadership in rural mental health is a serious void. To design and provide effective services which meet the needs of individuals with serious mental illness, rural consumers and families must be full participants in planning and program development. Services should not be planned or created without consumer and family input and agreement.

To ensure the active participation of consumers and their families, several adjustments must be made as to how the mental health system and rural providers of services typically conduct business. First, rural mental health professionals and programs need to acknowledge the importance of consumers and families and involve them in decision making at all levels. To make this change, training and leadership will be required. The literature supports the view of rural practitioners as individuals who are isolated, receive a limited amount of ongoing training and supervision, are reluctant to accept new technologies and types of services, and face significant barriers to collaboration (McDonel et al. 1997). The provision of meaningful roles for both consumers and providers, as well as the development of a truly collaborative relationship, is the goal. There must be a conscious commitment to assist consumers and their families to understand and utilize this new power.

Second, systems and programs must allocate resources so that consumers and families are able to be involved. Rural consumers are often poor and uninsured. They often cannot engage in the advocacy, or even be trained to engage in advocacy, without necessary financial support. Consumers and families rarely have the personal means to support their interests. Funding/service models exist, such as the Mental Health Empowerment
Project, Inc., in New York State, that have successfully addressed this issue. It should be reinforced, however, that individual programs or the State mental health authority need to take the steps necessary to formally support consumers and families.

Third, most often, sharing of power is the largest barrier, not regulations, standards, or funding mechanisms. It has been our experience that rural mental health providers are often viewed with a degree of respect not always enjoyed by their urban counterparts. In a role akin to the general practitioner, they are viewed as the experts who dispense care and advice. Many have come to enjoy their special place in rural America, and the empowerment of consumers and their families displaces them somewhat from this traditional role. Providers will need to deal with their personal sense of loss and with the impact of the changes resulting from an elevation of consumers and families in the planning and decision making chain. There is an enduring need for national and statewide leadership on this issue, with special attention to the needs of rural providers, services, and consumers.

**Making Information Technology Work for Rural Mental Health**

It is important to note that information technology is not a panacea for rural mental health. It should be seen as an extender of rural mental health services, and rural constituents should guard against replacing existing services with elemental health services. There are two very real sides to the coin of realizing the potential of information technology in rural mental health. The first is the availability and accessibility of this technology to rural mental health consumers, families, and practitioners. The second is the commitment of the rural mental health community to make effective use of this technology.

Access to information technology by rural mental health consumers and providers is analogous to the problems rural residents faced decades ago with electricity. It will likely take some form of government subsidization and perhaps rural cooperatives to achieve the kind of access to information technology that was achieved through rural electrification. Rural mental health providers need to join with other rural constituents to lobby for affordable connections to the information superhighway. As telehealth becomes a more common form of mental health service delivery, rural mental health consumers may be able to force increased access to these services by invoking the Americans With Disabilities Act. Rural mental health providers need to invest their resources in making information technology accessible to clients and their families. Rural clubhouses, day-treatment programs, and so forth should make Internet access available to consumers. National consumer and family organizations should use information technology to become more accessible to rural residents.

Accessibility to information technology does little good if it is not used. Rural mental health practitioners need to incorporate information technology into their repertoire of service delivery and make use of it to access professional support and continuing education. Rural mental health consumers need to learn how to leverage information technology as a tool in their own support and recovery. Rural mental health consumers, families, and practitioners need to utilize information technology to build virtual communities for support and political action.

The isolation of rural mental health has been one of the weaknesses in addressing rural mental health problems. The opportunities with information technology via the Internet can create virtual communities where common problems can be addressed, knowledge shared, support offered, and political action organized. This development of mutually supportive virtual communities has great potential to lessen the isolation and political fragmentation that has characterized rural mental health and to build strong coalitions that are not bound by geography, and political jurisdiction.
Rural mental health communities can be formed drawing upon people who live in geographically and culturally similar areas, such as the Great Plains. This would allow the creation of a larger constituency with increased resources and political clout. These kinds of connections have the ability to grow into organizational entities that have greater purchasing power and the ability to share resources and knowledge. For example, while it may not be feasible for a few small mental health programs in the frontier counties of a State to contract with an MCO to provide them administrative services such as billing and information systems tailored to their unique needs, it may be feasible for 50 rural mental health programs scattered across the Great Plains to do that.

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